Providence
Health Plan

2025 年

个人和家庭计划概述

Washington

Providence
Health Plan

全民健康

我们是一家拥有 160 多年历史的非营利医疗保健组织，致力于为社群的健康与福祉树立标杆。我们的目标不仅仅是治疗疾病，更在于促进健康。这意味着我们需要更早地进行干预，改善治疗效果，促进社群的健康水平。

作为一个综合系统，我们依托 Providence 的优质诊所、医院和医生网络，结合 Providence Health Plan 提供的灵活、实惠和卓越的服务，
为参保人带来真正独特的体验。

04 保险须知事项
06 主要福利
07 医疗保健方案
08 行为健康服务
10 参保人权益
11 如何选择保险计划？
12 查找提供者
13 医疗之家
15 Columbia 计划

保险须知事项

本手册提供了个人和家庭计划概览，每年可能会有所变动。有关保险计划福利、入保要求、限制和除外责任的更多信息，请参阅保险计划合同，或联系销售团队或您的保险代理人。如需查看福利和承保摘要 (Summary of Benefits and Coverage, SBC)，请访问：**ProvidenceHealthPlan.com/SBC**。

何时申请

在开放入保期内（2024 年 11 月 1 日至 2024 年 12 月 15 日），通过 Providence Health Plan 直接申请，保险的生效日期为 2025 年 1 月 1 日。如果您在 2024 年 12 月 16 日至 2025 年 1 月 15 日期间申请，则保险的生效日期为 2025 年 2 月 1 日。开放入保期结束后，您需要具备符合条件的生活事件，才能在特殊入保期内申请承保。如您非自愿丧失最低必要保险（不包括因未缴纳保费导致的失保），或因某些生活事件（如结婚或收养）而符合参保条件，则可以在特殊入保期内申领健康保险。有关更多信息及承保事件列表，请访问：**ProvidenceHealthPlan.com/QE**。

承保事件的生效日期

在特殊入保期内，保险生效日期取决于承保事件以及 Providence Health Plan 收到首期保费的时间。如果符合条件的事件是子女出生、收养、安置或寄养，或法院命令，保险将从事件发生之日起生效。如果您希望自行选择生效日期，请致电 **888-816-1300（听障用户专线：711）** 联系参保人核算部门获取进一步说明。所有其他承保事件的保险将从 Providence Health Plan 受理完整申请表后的下一个月的第一天起生效。

参保资格

如欲购买我们的保险计划，您必须居住在服务区域内，并且是 Washington 州的居民。Providence 的个人和家庭计划与 Medicare 不重复。已享有 Medicare A 部分或已加入 Medicare B 部分的人士不符合购买 Providence Health Plan 个人和家庭计划的资格。

申请和缴费日期

如欲通过 Providence Health Plan 直接申请，请访问 **ProvidenceHealthPlan.com/Shop** 使用在线购物和入保工具。在您提交在线申请时，系统将提示您提交首次保费。

月度保费支付信息

入保后，月度保费应于每月的第一天支付。
Providence Health Plan 建议您访问 **Providence.org/PremiumPay**，通过 Providence Health Plan 电子支付系统设置定期支付。
请注意：Providence Health Plan 不接受由雇主或第三方支付的保费，除非符合州或联邦法规的要求。

健康保险术语

请访问 **ProvidenceHealthPlan.com/Glossary** 查看健康保险术语的解释和定义。

隐私保护通知

访问 **ProvidenceHealthPlan.com** 了解 Providence Health Plan 隐私保护政策。您也可以访问 **ProvidenceHealthPlan.com/NOPP** 或致电客户服务部 **800-878-4445（听障用户专线：711）** 获取 Providence Health Plan 隐私保护通知的副本。

主要福利

无需转诊

Providence Choice 网络不要求转诊即可访问网络内的专科医生，确保您能够更方便地获得所需的医疗保健服务。

全额赔付

Providence ExpressCare 诊所和线上就诊均为全额承保服务。您可以预约当日线下就诊，或通过平板电脑、智能手机或电脑，只需等待几分钟，即可获取医疗保健服务。

替代疗法承保

所有保险计划均承保脊椎按摩（每年限 10 次）、针灸（每年限 12 次）、按摩疗法（每年限 10 次）等替代疗法。您可以向自然疗法或其他替代疗法提供者寻求定期检查和婴幼儿保健等承保服务。只要替代疗法提供者具有提供相关服务的执照，则承保比例应与初级保健提供者相同。

参保人安全门户

myProvidence 支持通过平板电脑、智能手机或电脑按需访问个性化健康保险计划信息。参保人还可以通过 myProvidence 访问工具和资源，帮助您管理健康保险和福利，使其得到充分利用。

myProvidence 功能包括：

- 查看理赔信息和福利说明 (Explanation of Benefit, EOB)
- 监控自付额和自付上限的进展
- 使用提供者目录搜索网络内的医疗服务提供者
- 打印并替换 ID 卡

药房费用节省

您是否在寻找节省药费的方法？在某些保险计划中，邮购下单 90 天的处方药，费用与 60 天的开销相同。仅适用于 1-4 级。

医疗保健方案

多种方案可供选择，您可以随时随地在家中或亲自前往医疗保健机构获得所需服务。

初级保健

与您的初级保健提供者 (Primary Care Provider, PCP) 会面，建立信任关系并创建个性化健康档案。如果您需要初级保健提供者，请访问 **myProvidence.com**，登录后选择 Find a Provider（查找提供者）。然后选择 Primary Care Providers（初级保健提供者）。

远程医疗（电话或视频预约）*

安排电话预约，随时随地与您的提供者交谈。您也可以
通过 Zoom 等视频会议平台预约与 PCP 或专科医生的视频会诊。

24 小时护士咨询热线 (ProvRN)

如果您有健康问题、新生儿患病，或者需要健康建议，可随时与执业护士联系。护士可以帮助您判断是否需要线下就诊。请准备好您的参保人 ID 号码，并致电 **800-700-0481**。

ExpressCare 线上服务

您可通过电话或视频在几分钟内获取医疗保健服务，处理如感冒、流感、发烧等常见问题，或结膜炎、喉炎、支气管炎等感染性疾病。线上就诊还可以解决生殖健康和儿科健康问题，提供处方续药服务，并安排化验或手术。如欲了解入门指南，请访问 **Providence.org/Services/ExpressCare-Virtual**。

ExpressCare 诊所

预约当天的线下就诊或在可行的情况下直接前往。处理如感冒、喉咙痛或过敏等常见疾病。大多数诊所的营业时间为 7 a.m. 至 7 p.m.，或 8 a.m. 至 8 p.m.（太平洋时间）。如欲查找地点并预约，请访问 **Providence.org/ExpressCare**。

紧急医疗

如您无法等待初级保健预约，可以前往紧急医疗保健诊所治疗割伤、烧伤或疼痛等轻伤。如欲查找紧急医疗保健诊所，请登录 **myProvidence.com**，并选择 Find a Provider（查找提供者）。然后选择 Find a Service or Place（查找服务或地点）；Urgent Care Clinic（紧急医疗保健诊所）。

急诊护理

如果您出现危及生命的情况，请拨打 911 或就近前往急诊室。急诊适用于如疑似心脏病发作、剧烈腹痛、中毒或意识丧失等症状。

> **如欲了解更多信息，请访问**
> **ProvidenceHealthPlan.com/Care-Options.**

*远程医疗服务视可用性而定，请联系医生办公室，咨询能否提供此项服务。

行为健康服务

为您提供更多获取所需医疗保健服务的途径。

在 Providence Health Plan，我们理解，在面对行为健康问题时，不能采用“一刀切”的解决方案。每个人都是独一无二的。因此，我们提供多种服务，为您提供支持，助您取得积极的成果。

以下是产品及服务概览。

提高健康生活质量的资源

有助于放松与恢复的资源

- 按摩疗法、瑜伽、冥想等服务优惠
- ProvidenceHealthPlan.com/LifeBalance

自我管理与正念工具

健康辅导

- ProvidenceHealthPlan.com/HealthCoaching
- 一对一健康辅导
- 设定个性化的目标与可行的步骤
- 旨在帮助您实现健康目标的计划

Learn to Live

- LearnToLive.com/Welcome/ProvidenceHealthPlan
- 自主线上疗法，管理心理健康
- 一对一辅导、正念练习，以及直播和点播的网络研讨会
- 随时通过应用程序获取服务

远程医疗/线上资源

行为健康管家

- Providence.org/BHC
- 与 Providence 签约提供者快速联系，获得所需的医疗保健服务
- 营业时间延长，7 a.m. - 8 p.m.（太平洋时间），每周 7 天
- 帮助解决生活压力、心理健康及成瘾问题
- 适用于居住在 Oregon (OR)、Washington (WA)、Idaho (ID)、California (CA)、Montana (MT) 和 Texas (TX) 且符合条件的参保人

Talkspace

- Talkspace.com/ProvidenceHealthPlan
- 线上心理治疗的远程医疗提供者，适用于 13 岁以上青少年及成人
- 在 48 小时内为您匹配治疗师
- 通过文本、电话或视频进行沟通
- 提供心理治疗、精神科服务*或二者兼有

*精神科医生可以开具处方药物。

如欲了解更多信息，请访问
ProvidenceHealthPlan.com/BehavioralHealth

服务成效

Talkspace

80%

的患者认为 Talkspace 与传统治疗同样有效或更有效

行为健康管家

42%

的参保人表示，如无此项服务，他们不会主动寻求帮助

Learn to Live

44%

此数据为患者与 Learn to Live 教练合作后，心理测量结果的改善比例

Equip

81%

的患者饮食失调症状得到改善

Charlie Health

60%

抑郁症状得到缓解

Joon Care

87%

的患者从严重症状中有效恢复

广泛的临床网络

行为健康网络

- 本地及全国范围的就诊
- 线下服务和线上服务
- 针对不同年龄段的关怀服务（儿童、青少年、成人）
- 访问专业的行为健康网络

提供者目录

- **ProvidenceHealthPlan.com/FindAProvider**
- 进入提供者目录 (Provider Directory)，使用您的参保人 ID 号进行搜索
- 选择 Find a care provider（查找医疗保健服务提供者）
- 选择“心理健康/物质使用障碍 (Mental Health/Substance Use Disorder)”

关怀服务和危机干预

行为健康中心

- 一周 7 天 24 小时即时访问
- 团队接受过危机分诊护理培训
- 实时转诊服务
- **800-878-4445（听障用户专线：711）**

紧急医疗与急诊护理服务

- 住院护理
- 非全日式住院护理

Equip

- 饮食失调线上治疗
- 针对 6-24 岁儿童及青少年
- 以家庭为基础的治疗 (Family-Based Treatment, FBT)，由多学科团队提供

Charlie Health

- 虚拟强化门诊项目（Virtual Intensive Outpatient Program, vIOP）
- 针对 11-30 岁的少年及青年
- 个性化治疗计划，包括团体治疗和居家/个人治疗

Joon Care

- 自杀及危机干预
- 与持证治疗师进行线上会话
- 针对 13-26 岁的少年及青年
- 适用于居住在 OR、WA、TX、CA、Delaware (DE)、Pennsylvania (PA) 和 New York (NY) 且符合条件的参保人

如果您或您认识的人需要即时的危机干预服务，请致电或发送短信至 988 自杀和危机生命热线。

参保人权益

探索更多保障您生活各方面的其他福利和项目。

One Pass Select™

通过一项经济实惠的计划，促进全身健康。选择适合您生活方式的投保级别，获取数字健身应用程序、健身房会员和家庭杂货配送服务。每天花费不到 $1 即可开始您的健康之旅。

LifeBalance

LifeBalance 为参保人及其家人提供电影票、度假等活动的折扣。它将帮助您保持活力，减轻压力，并在成千上万的娱乐、文化、健康和出行相关产品中节省开支。

健康辅导*

无论您是想提高活动水平，减轻压力，改善饮食习惯，减肥，戒烟，还是仅仅想让自己感觉更好，Providence 健康教练都能为您提供帮助。我们将为您扫除障碍，在您需要鼓励的时候为您提供动力，并成为您旅途中的资源。

Travel Assistance®

我们与 Assist America Travel Assistance® 合作，为您在外出时的紧急医疗需求提供后勤支持。例如帮助您迅速入住符合条件的医院，或补发遗落的处方药，等等。

身份保护

Assist America 保护您的个人数据不被盗用，并在数据遭到冒用时恢复数据的完整性。将重要信息存储在安全的地方，若丢失或被盗，通过快捷、便利的流程即可解决问题。

如欲了解更多关于上述福利的详细信息，请访问 ProvidenceHealthPlan.com/Member-Perks。

*适用资格和参与条件。并非所有参保人都可享受健康辅导服务。如欲了解计划资格，请联系健康辅导项目团队。

如何选择保险计划？

在为您和您的家人选择健康保险计划之前，请务必考虑多种因素——例如保费、护理需求、是否有慢性疾病、目前是否服用任何药物？在选择合适的保险计划，以期平衡月度保费和自付费用时，上述因素同样值得考虑。

选择合适的医疗网络也非常重要，这关系到您如何获得所需的医疗服务。您的网络包括健康保险计划的签约提供者和医疗设施。请务必确认您的医生是否在服务区域内。

如何选择适合的保险计划

Gold、Silver 或 Bronze，哪种保险计划适合您？有几个方面需要考虑，一切都始于您和您的家人对医疗服务的预期需求。根据您选择的级别，保费和自付费用将有所不同。但有一点永远不会改变，那就是您获得的医疗服务质量。

下文为您提供了一份快速指南，介绍不同层级、各自优势以及适用人群：

Gold

如果您经常去医生或其他专科医生处就诊，或者预期需要大量医 适合定期去医生或专科医生处就诊，但看诊频率低于 Gold 级用户的人群。

如果您身体健康且不需要频繁的医疗保健服务，Bronze 级将非常适合您。其保费为三者中最低，但自付费用通常较高。

Bronze

保险咨询服务

如需保险咨询服务，请致电 **800-988-0088（听障用户专线：711）** 或访问 **ProvidenceHealthPlan.com/Shop**。

查找提供者

自定义搜索医疗服务提供者，仅需三个步骤。

通过在线提供者目录，轻松查找网络内的提供者。无论您需要查找初级保健提供者、专科医生、医疗之家、药房还是医疗设施，只需点击几下即可找到您所需的服务。

以下是搜索提供者的方法：

01 **搜索**

访问 **ProvidenceHealthPlan.com/FindAProvider**，查看网络内提供者、药房和医疗设施的完整列表

02 **定制搜索**

选择 Find a care provider（查找医疗保健服务提供者），然后按照提供者类型、服务或地点进行搜索

03 **定制搜索结果**

使用左侧菜单，根据身份信息，进一步定制搜索结果

按以下条件筛选结果：

- 类型/专科
- 地点
- 医院隶属关系
- 性别
- 语言
- 种族和族裔
- 宗教信仰
- 个人身份
- 文化适应性
- LGBTQ+
- 相关社群

如需帮助，请致电客户服务部（Customer Service）：**800-878-4445（听障用户专线：711）**周一至周五 8 a.m. 至 5 p.m.（太平洋时间）。

医疗之家

参保人可从多种方案中选择适合自己的医疗保健服务。医疗之家将参保人的需求置于每次医疗保健服务的核心。

医疗之家是一种以团队为基础的医疗模式，由您的初级保健提供者领导。他们将与其他医疗专业人员（如护士、专科医生和药剂师）协作，协调您的医疗保健服务——这就是所谓的“医疗保健团队”。医疗团队成员将齐心协力，确保在您的健康问题上达成一致。

您的初级保健提供者可以是医生也可以是护士，其将作为医疗保健团队的领导者，倾听您的需求并指导您接受治疗。

其他医疗保健专业人员，如您的医疗保健团队，将充分了解您的个人健康状况。

协调的医疗服务保险计划将确保参保人、医疗保健团队和健康保险计划保持一致。通过上述协作，投保人每次就诊时无需重复阐述个人病情。

医疗之家的优势

Providence 医疗之家能让您更容易地获得周到的医疗保健服务：

- 医疗团队了解您的健康状况，并将与您建立个性化体验。
- 可在方便的地点找到首选提供者，无需费时寻找。
- 综合团队将提供医疗保健服务并加以管理，包括在必要时协调预约和处方的相关事宜。

Columbia 计划

保险计划亮点：

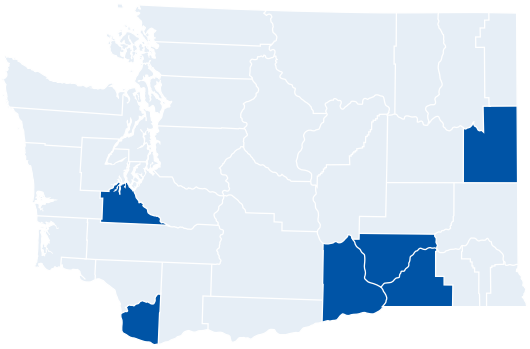
- 脊椎按摩、针灸和按摩疗法属于网络内承保范围。
- Columbia 计划无需专科医生转诊。
- 此保险计划不包含网络外的福利。除紧急医疗与急诊护理服务外，您必须使用网络内的提供者才能享受福利。
- 您可以向网络内的自然疗法提供者寻求定期检查和婴幼儿保健等承保服务。只要替代疗法提供者具有提供相关服务的执照，则承保比例应与初级保健提供者相同。

> 如欲比较保险计划、查看费率或投保，请访问 **ProvidenceHealthPlan.com/shop**。

Providence Choice 网络

该网络在以下郡域设有多家被指定为医疗之家的初级保健诊所：

- Benton
- Clark
- Franklin
- Spokane
- Thurston
- Walla Walla



Columbia 计划	Columbia 1500 Gold 网络内 (网络外无福利)	Columbia 5000 Silver 网络内 (网络外无福利)	Columbia 8900 Bronze 网络内 (网络外无福利)
免赔额			
个人全年免赔额(1 人)	$1,500	$5,000	$8,900
家庭全年免赔额(2 人或以上)	$3,000	$10,000	$17,800
个人全年自付额上限(1 人)	$8,200	$8,900	$8,900
家庭全年自付额上限(2 人或以上)	$16,400	$17,800	$17,800
在达到免赔额后,您需要支付以下金额以获取承保服务。 带有 ✓ 标记的服务不适用于免赔额。			
预防保健			
定期体检和婴幼儿保健(由任何获得服务许可的提供者提供)	全额承保✓	全额承保✓	全额承保✓
产妇产前门诊	全额承保✓	全额承保✓	全额承保✓
年度妇科检查 和子宫颈抹片检查	全额承保✓	全额承保✓	全额承保✓
乳房 X 光检查	全额承保✓	全额承保✓	全额承保✓
结肠直肠癌筛查 (45 岁及以上的预防人群)	全额承保✓	全额承保✓	全额承保✓
医疗服务门诊			
初级保健提供者 (PCP)	$30✓	$45✓	$70✓
ExpressCare 线上就诊	全额承保✓	全额承保✓	全额承保✓
替代疗法提供者	$30✓	$45✓	$70✓
专科医生	$50✓	$65✓	$100✓
医院服务			
住院服务 和产科护理	20%	35%	全额承保
紧急医疗和急诊护理			
紧急医疗服务 (所有服务均视为 网络内服务)	$250,后续为 20%	$250,后续为 35%	全额承保
急诊护理服务 (非网络内 服务适用免赔额)	$50✓	$65✓	$100✓

表格后续部分见下页

Columbia 计划	Columbia 1500 Gold 网络内 (网络外无福利)	Columbia 5000 Silver 网络内 (网络外无福利)	Columbia 8900 Bronze 网络内 (网络外无福利)
门诊诊断服务			
X 光和化验服务	20%✓	35%✓	全额承保
高科技影像服务(如正电子发射断层扫描 (Positron Emission Tomography, PET)、计算机断层扫描 (Computed Tomography, CT)、磁共振成像 (Magnetic Resonance Imaging, MRI))	20%	35%	全额承保
心理健康与药物使用障碍			
住院和住院治疗服务	20%	35%	全额承保
门诊就诊	$30✓	$45✓	$70✓
其他承保服务			
门诊手术(在门诊手术中心进行)	10%	25%	全额承保
脊椎按摩(每年限 10 次)	$25✓	$25✓	$25✓
针灸(每年限 12 次)	$25✓	$25✓	$25✓
按摩疗法(每年限 10 次)	$25✓	$25✓	$25✓
处方药			
第 1 级	全额承保✓	全额承保✓	全额承保✓
第 2 级	$10✓	$25✓	$35✓
第 3 级	$50✓	$70✓	全额承保
第 4 级	50%	50%	全额承保
第 5 级	50%,每个处方上限 $200	50%,每个处方上限 $200	全额承保
第 6 级	50%	50%	全额承保
胰岛素最高限额			
30 天供应量	$35✓	$35✓	$35✓
小儿视力服务(18 岁及以下儿童)			
常规眼科检查	全额承保✓	全额承保✓	全额承保✓
视力设备(镜架、镜片、隐形眼镜);适用限额	全额承保✓	全额承保✓	全额承保✓

> 请访问 **ProvidenceHealthPlan.com/Shop** 或通过本地保险代理人购买 Columbia 计划。

✓此服务无免赔额。

除非母体遭遇严重生命威胁,或胎儿无法存活,否则本保险计划不承保妊娠终止服务。Providence 基于宗教原因,反对在其他情况下提供此类服务。然而,本保险计划的参保人可通过 Washington 州卫生部家庭计划项目 (Washington Department of Health Family Planning Program) 获得妊娠终止服务的承保。如需获取相关服务信息,请联系卫生部 (Department of Health) 客户服务专线 1-877-501-2233。无需向 Providence Health Plan 通报或与其沟通此类非承保服务。

非歧视声明

Providence Health Plan 和 Providence Health Assurance 遵守适用的联邦民权法律，并且不因种族、肤色、国籍、年龄、残疾、性取向、宗教、性别认同、婚姻状况或性别而歧视任何人。Providence Health Plan 和 Providence Health Assurance 不排斥任何人，也不会因为种族、肤色、国籍、年龄、残疾、性取向、宗教、性别认同、婚姻状况或性别而产生差别对待。

Providence Health Plan 和 Providence Health Assurance：

为残障人士提供以下免费的帮助和服务，以便有效沟通，如：

- 资质完备的手语翻译
- 其他格式的书面信息（大字版、音频、无障碍电子格式等）

为母语非英语者提供免费的语言服务，如：

- 资质完备的翻译
- 其他语言的书面信息

如需获取上述服务，请致电 **503-574-7500** 或 **800-878-4445（听障用户专线：711）** 联系我们。

如果您认为 Providence Health Plan 和 Providence Health Assurance 未能提供这些服务，或在种族、肤色、国籍、年龄、残疾、性取向、宗教、性别认同、婚姻状况或性别方面存在歧视行为，您可以通过邮寄方式向我们的非歧视协调员 (Non-discrimination Coordinator) 提出投诉：

Providence Health Plan and Providence Health Assurance
Attn:Ronni Nichuals, Non-discrimination Coordinator
P.O. Box 4158
Portland, OR 97208-4158
电话：**503-574-6236**
传真：**503-574-8757**
电子邮件：**Ronni.Nichuals@Providence.org**

如果您在提交投诉时需要帮助，请致电 **503-574-7500** 或 **800-878-4445（听障用户专线：711）** 寻求帮助。

您也可以通过以下方式向美国卫生与公众服务部 (U.S. Department of Health and Human Services，HHS) 民权办公室 (Office for Civil Rights) 提出民权投诉：通过民权办公室投诉门户进行电子提交：**https://ocrportal.hhs.gov/orc/portal/lobby.jsf**；通过邮递或电话提交：

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201
电话：**800-368-1019** 或 **800-537-7697（听障用户专线）**

投诉表格可通过 **https://www.HHS.gov/OCR/office/file/index.html** 获取。

Oregon 州保单持有人可以拨打**888-877-4894** 或访问 **https://dfr.oregon.gov/pages/index.aspx** 向金融监管部 (Division of Financial Regulation) 提交投诉。

Washington 计划参保人可通过 Washington 保险专员办公室 (Washington Office of the Insurance Commissioner) 的保险专员办公室投诉处理 (Office of the Insurance Commissioner Complaint) 门户在线提出投诉 **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**，或通过电话 **800-562-6900** 或 **800-537-7697（听障用户专线：711）** 或访问 **www.insurance.wa.gov** 提起投诉。投诉表格可通过 **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx** 获取。

语言服务信息

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ：日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。 1-800-878-4445 (TTY: 711)まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອ ດ້ານພາສາ ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).

Providence Health Plan

全民健康

我们致力于与所服务的社群携手合作，了解独特的医疗保健挑战，并制定切实可行的解决方案，以促进医疗保健的公平性和可及性。

保险咨询服务

800-988-0088（听障用户专线 (TTY)：711）

8 a.m. 至 5 p.m.（太平洋时间），周一至周五。

ProvidenceHealthPlan.com/Shop

24_PHP_00610 10/24 IND-066C_CH

Providence Health Plan

PO Box 4649, Portland, OR 97208-4649

2025 Washington Application for Individual & Family Insurance

Thank you for choosing Providence Health Plan for your individual health insurance coverage.

THIS FORM IS FOR NEW ENROLLMENT ONLY. DO NOT USE THIS FORM IF:

- **You currently have an active Providence Health Plan Individual & Family insurance plan in the state of Washington. To learn how to make changes to your existing plan, please see the attached Additional Information page.**
- **You're entitled to Medicare Part A and/or enrolled in Medicare Part B. For information about Providence Medicare plans, please visit ProvidenceHealthPlan.com/Medicare.**

For assistance completing your application, please contact the Providence Health Plan Sales team at 503-574-5000 or 800-988-0088 (TTY: 711), 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday. You may also contact your insurance agent/producer for assistance.

Before You Begin

Here's some important information about this form.

Everyone listed on this form will be enrolled in the same single plan. A separate application is required for any family members who want coverage on different plans.

All plans purchased using this application will expire December 31, 2025. All plans under the Affordable Care Act (ACA) are considered to be guaranteed renewable. Providence Health Plan will send you information at the end of the plan year regarding your eligibility for coverage in 2026.

Learn about different plans, compare coverage and check rates at ProvidenceHealthPlan.com.

This form does NOT cancel any active coverage you might already have. To avoid paying two premiums or having overlapping coverage, you need to cancel any currently active coverage you might have on a plan from either the Health Benefit Exchange or an employer, even if the policy is with Providence Health Plan.

Once you've completed this form, submit pages 1-8 to Providence Health Plan. If the form isn't signed, dated, fully completed, or if we need additional information, the date your coverage starts may be delayed. Your application will expire 60 days after the signature date, and we will not accept any postdated applications.

Step 1 of 5: Select Enrollment Period

Select one of the following enrollment options:

Option 1:

☐ I'm enrolling for new coverage during the **Open Enrollment Period (11/1/2024 - 1/15/2025)**.

Open Enrollment is your opportunity to enroll for coverage without requiring a qualifying event. For your coverage to be effective January 1, 2025, Providence Health Plan must receive your completed application no later than 12/15/2024.

Applications received between 12/16/2024 - 1/15/2025 will have coverage effective February 1, 2025. To effectuate coverage, you must submit your initial premium payment by the due date listed in Providence Health Plan's offer of coverage.

Option 2:

☐ I'm enrolling for new coverage during a **Special Enrollment Period (1/1/2025 - 12/31/2025)**.

You must have experienced one of the qualifying events listed below and submit your application and required documentation. Providence Health Plan must receive this completed application and required documentation **within 60 days** of the qualifying event.

Your effective date will be determined based on the type of qualifying event and the date Providence Health Plan receives your completed application, conditioned on timely receipt of your initial premium payment. Your effective date cannot be prior to the qualifying event. Please see the attached **Additional Information page** to learn more.

_____ /_____ /_____

DATE OF QUALIFYING EVENT

If you're applying outside of the Open Enrollment Period you must select a qualifying event:

- ☐ Involuntary loss of individual or group coverage except for failure to pay the premium
- ☐ Marriage or state registered domestic partnership*
- ☐ Birth, adoption, placement for adoption or foster care of a child
- ☐ Qualified Medical Child Support Order (QMCSO) or acquisition of legal guardianship
- ☐ Permanent move to a new Providence Health Plan service area that offers different health plan options
- ☐ Loss of coverage as a dependent due to age
- ☐ Loss of coverage due to end of marriage or state registered domestic partnership
- ☐ Involuntary loss of Medicaid or CHIP coverage
- ☐ Newly eligible for a state- or federally-sponsored premium assistance program
- ☐ Loss of Advance Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), or cessation of employer contribution to COBRA
- ☐ Newly gains access to an individual coverage HRA (ICHRA) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA)
- ☐ Survivor of domestic abuse/violence or spousal abandonment and wants to enroll in a health plan separate from the abuser or abandoner

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

Step 2 of 5: Provide Member Information

Who is this application for? (Select one)

- ☐ **Myself only:** You must be at least 18 years old and reside in our service area.
- ☐ **Myself and my spouse/state registered domestic partner:*** Includes you and your spouse or state registered domestic partner. Both must reside in our service area.
- ☐ **Myself and my children:** Includes you, your dependent children age 25 or younger, and disabled dependents. You, the Policyholder, must reside in our service area.
- ☐ **Myself and my family:** Includes you, your spouse or state registered domestic partner, your dependent children age 25 or younger, and disabled dependents. Both you and your spouse/domestic partner must reside in our service area.
- ☐ **My dependent(s) only:** Includes your spouse or state registered domestic partner, your dependent children age 25 or younger, and disabled dependents. The responsible parent or legal guardian is the Policyholder. All enrolled dependents must reside in our service area.

*"State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

Applicant/Policyholder Information

The policyholder must be at least 18 years old, is financially responsible for the policy and is the person authorized to make changes to the plan.

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH MM/DD/YYYY ___/___/___

SOCIAL SECURITY # ___-___-_____ EMAIL ADDRESS _____ PHONE # ___-___-_____

Gender (check one) ☐ Male ☐ Female ☐ Other

How do you identify? (These fields are optional. Your response will help us to better serve all communities.)

☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

Have you used any tobacco products in the last six months? ☐ Yes ☐ No

(Tobacco use is defined as an average of at least four times per week in the last six months, except for religious or ceremonial purposes.)

PHYSICAL ADDRESS (NO P.O. BOX OR RETAIL/BUSINESS ADDRESSES) _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS) _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

Step 3 of 5: List Dependents

Dependent Information

Please include full, legal names. For all plans, dependent children must be age 25 or younger as of their effective date.

1

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

2

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

3

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

* "State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

**Tobacco use is defined as an average of a least four times per week, except for religious or ceremonial purposes.

***These fields are optional. Your response will help us to better serve all communities.

Step 3 of 5: List Dependents

Dependent Information (Continued)

Please include full, legal names. For all plans, dependent children must be age 25 or younger as of their effective date. If you have additional dependents to be enrolled, please include them on a separate sheet with this enrollment application.

4

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

5

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

6

LAST NAME _____ FIRST NAME _____ MI _____ DATE OF BIRTH ____/____/____

RELATIONSHIP* _____ SOCIAL SECURITY # ___-___-____

GENDER: ☐ M ☐ F ☐ Other

USES TOBACCO?** ☐ Yes ☐ No

HOW DO YOU IDENTIFY?*** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Decline to answer

LIVES WITH POLICYHOLDER? ☐ Yes ☐ No **IF NO, INCLUDE THE DEPENDENT'S PHYSICAL ADDRESS BELOW.**

DEPENDENT'S PHYSICAL ADDRESS _____ APARTMENT/UNIT NUMBER _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

* "State registered domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030, and who have been issued a certificate of state registered domestic partnership by the secretary.

**Tobacco use is defined as an average of a least four times per week, except for religious or ceremonial purposes.

***These fields are optional. Your response will help us to better serve all communities.

Step 4 of 5: Select a Plan

You can learn more about each of the medical plans listed below by reading their corresponding Summary of Benefits and Coverage (SBC) at **ProvidenceHealthPlan.com/SBC**.

APPLICABLE COUNTIES	NETWORK	MEDICAL PLAN (CHECK ONE)
Benton, Clark, Franklin, Spokane, Thurston, Walla Walla	Choice	☐ Columbia 1500 Gold ☐ Columbia 5000 Silver ☐ Columbia 8900 Bronze

You will need to choose a Medical Home and a Primary Care Provider (PCP) after you enroll. Find a participating Providence Health Plan provider at **ProvidenceHealthPlan.com/FindAProvider**. To learn about Medical Homes, please see the attached **Additional Information page.**

Step 5 of 5: Read, Sign & Submit

Certification of Completion and Correctness

I affirm that the answers given in this Application for Coverage are complete and correct. I am providing these answers as part of the application procedure required by Providence Health Plan to enroll for insurance coverage.

I understand that if this application contains any intentional material misstatements or omissions, other than misstatements or omissions related to the use of tobacco products, Providence Health Plan may rescind, modify or cancel the contract, and/or take any other legal action available to it by law. I understand that misstatements or omissions related to tobacco use may result in rate modification, to the extent permissible under state and federal law. I will promptly inform Providence Health Plan in writing if anything changes before my coverage takes effect that makes this application incomplete or incorrect.

I understand and agree that no coverage shall be in force until the effective date determined by Providence Health Plan and that Providence Health Plan may contact me to clarify answers on this application.

As the applicant, I understand I have the right to inspect the information in my file. I understand that I can visit **ProvidenceHealthPlan.com** to educate myself about Providence Health Plan's privacy practices. I understand that I can get a copy of Providence Health Plan's Notice of Privacy Practices by going to **ProvidenceHealthPlan.com/NOPP** or by calling Customer Service at 503-574-7500 or 800-878-4445 (TTY: 711).

Sign on next page →

Signature

1. I understand that this is an individual health insurance contract and I verify that neither my employer nor any third party will be paying the premium on this policy except as permitted by state or federal regulation.
2. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
3. I understand that I must update my information with Providence Health Plan anytime there are changes from what I wrote on this application.
4. I verify that neither I nor any of my enrolled dependents are entitled to Medicare Part A and/or enrolled in Medicare Part B. (The federal government does not allow health plans to issue Individual coverage that duplicates coverage available through Medicare.)
5. I am the parent or legal guardian of all dependent children listed on this application.
6. I verify that the physical address I provided on this application for myself is accurate, as well as any other address provided by me for any dependents included on this application.
7. Providence Columbia plans DO NOT include pediatric dental coverage. I affirm that I will obtain pediatric dental coverage; for dependents under age 19 through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage. I understand that if I do not obtain pediatric dental coverage, Providence Health Plan will discontinue my or any of my enrolled dependents health benefits until reasonable assurance is obtained.
8. I understand that:
   - Providence Health Plan will send me an offer of coverage containing the terms for initial premium payment.
   - I need to pay my initial premium payment by the due date specified on my offer of coverage to effectuate my policy.
   - After my policy has been effectuated, Providence Health Plan will send me a legal contract.
9. I understand that this application does not terminate other coverage through the Health Benefit Exchange, Providence Health Plan or other carriers.

By signing, I agree to the above conditions. Policyholder signature and date required.

Signature is considered valid only if it is hand written ("wet") or e-signed.
A copy of legal guardianship or power of attorney must accompany this form if not signed by the Policyholder.

_____ _____ / _____ / _____

SIGNATURE OF POLICYHOLDER, LEGAL GUARDIAN OR POWER OF ATTORNEY DATE MM/DD/YYYY

_____

PRINT NAME

☐ Signed by Policyholder Applicant for Spouse or Domestic Partner

_____

SIGNATURE OF SPOUSE OR DOMESTIC PARTNER (IF APPLICABLE)

For Producer Use Only

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Providence Health Plan.

I have informed the applicant that the effective date of coverage is assigned only by Providence Health Plan and provided the Washington Disclosure Information required. I certify that the information supplied to me by the applicant has been truly and accurately recorded here. **All fields are required.**

PRODUCER NAME

AGENCY NAME

PRODUCER NPN

EMAIL ADDRESS

DATE MM/DD/YYYY

PRODUCER SIGNATURE

Submission Instructions

01 Review your completed application to make sure you didn't miss anything.

Important reminder: if your application is incomplete, lacks a signature or signature date, or if additional information is required, your effective date may be delayed. Your application will expire 60 days after the signature date, and we do not accept any postdated applications.

02 Mail pages 1–8 to: or Fax pages 1–8 to:

Providence Health Plan
P.O. Box 4649
Portland, OR 97208-4649

503-574-8131

03 What happens now?

- Providence Health Plan will send you an offer of coverage that will include the amount of your initial premium payment and when it's due.
- In order for your coverage to take effect, Providence Health Plan must receive your initial premium payment by the due date listed in our offer of coverage.
- Please save a copy of this completed application for your records.

Race/Ethnicity Questionnaire

Providence Health Plan

The following questions are optional. Your responses will help us to better serve all communities.

Which of the following describes your racial or ethnic identity? Please check all that apply.

Hispanic and Latino/a/x

- ☐ Hispanic or Latino/a/x Central American
- ☐ Hispanic or Latino/a/x Mexican
- ☐ Hispanic or Latino/a/x South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Other

- ☐ Other
- ☐ I don't know.
- ☐ I don't want to answer.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

White

- ☐ Caucasian/White (no national affiliation)
- ☐ Eastern European/Slavic
- ☐ Western European
- ☐ Other White (African, Australian, New Zealand descent)

Middle Eastern or North African

- ☐ Middle Eastern
- ☐ North African

Black or African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Afro-Latinx/Bi-racial/Other
- ☐ Other Black

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- ☐ **Yes** (please specify): _____
- ☐ **No:** I do not have just one primary racial or ethnic identity.
- ☐ **No:** I identify as Biracial or Multiracial.
- ☐ **N/A:** I only checked one category above.
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

What is your preferred spoken language?

- ☐ English
- ☐ Spanish
- ☐ Chinese - Other
- ☐ Mandarin
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ German
- ☐ French
- ☐ Tagalog
- ☐ Japanese
- ☐ Korean
- ☐ Arabic
- ☐ Decline/Unknown
- ☐ Other

What is your preferred written language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ Simplified Chinese
- ☐ Russian
- ☐ Other
- ☐ **N/A:** I don't know.
- ☐ **N/A:** I don't want to answer.

Additional Information

What is a Medical Home?

When you enroll in a Columbia plan, you are required to choose a Medical Home (also known as a Primary Care Home). A Medical Home is a cooperative, patient-centered clinic made up of providers and staff who work with you to address your physical and behavioral health needs and goals. The Medical Home you choose coordinates all elements of your care across hospitals, specialists, pharmacies, home health services, and community resources to ensure greater accessibility, shorter wait times, and an integrative approach to your health.

I'm signing up during a Special Enrollment Period due to a qualifying event. When will my coverage take effect?

If the qualifying event is birth, adoption, placement for adoption or foster care of a child, or a court order, coverage will be effective from the date of the event. If you would prefer a prospective effective date, please call Membership Accounting at 503-574-5791 or 888-816-1300 (TTY: 711) for further instructions. All other qualifying events will be effective on the first day of the month following Providence Health Plan's receipt of your completed application. For further instructions and details related to a Special Enrollment Period, visit **ProvidenceHealthPlan.com/QE**.

How do I make changes to an existing plan?

If you are an active Individual & Family Plan policyholder in the state of Washington and would like to make changes to your current plan, visit **ProvidenceHealthPlan.com/Forms** to complete an Individual & Family Plan Change Form.

This application form is only for new enrollment in an Individual & Family plan purchased directly from Providence Health Plan. That means if you are an active member and submit this application for new enrollment, you will be enrolled in a new policy which will result in duplicate coverage and two premium payments.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

Providence Health Plan

保险咨询服务

800-988-0088（听障用户专线 (TTY)：711）

8 a.m. 至 5 p.m.，（太平洋时间），周一至周五

ProvidenceHealthPlan.com/Shop

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